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MEDICAID MEMO

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Implementation of Medicaid Reimbursement Process for Hospital Acquired Conditions – Effective January 1, 2010

According to Item 306.ZZ of the 2009 Appropriations Act, DMAS shall have the authority to "eliminate reimbursement for Hospital Acquired Conditions in a manner similar to the Medicare initiative implemented October 1, 2008."

In a previous memo dated May, 2009, titled Revision of the Present on Admission Indicator, Implementation of Never Events Policy, and Information on Hospital Acquired Conditions Policy, DMAS announced plans to require the Present on Admission (POA) indicators for all diagnoses on inpatient hospital claims effective July 1, 2009. POA indicators are necessary prerequisites to implementing the Hospital Acquired Conditions policy.

The purpose of this memo is to alert all providers who currently submit inpatient acute care hospital claims on paper (UB) and Electronic Data Interchange (EDI) 837 Institutional that effective with claims received on or after January 1, 2010, DMAS will implement the Center for Medicare and Medicaid Services (CMS) Hospital Acquired Conditions (HAC) payment provision.

CMS has identified specific HACs that are associated with the Present on Admission (POA) indicator. POA indicators will be used in determining which diagnosis codes will be considered when assigning the DRGs and will potentially affect the provider reimbursement amount. The diagnosis codes that are taken under consideration as HACs require a POA indicator to determine whether they will be included in the DRG Grouper. If the primary, secondary, or external diagnosis code has a POA indicator of N or U, and a HAC is present, that code will be excluded from the DRG grouper. Only those HACs with a POA code of 'Y' or 'W' will be included in the DRG grouper. If the POA indicator is a 1 or blank, and the diagnosis code is exempt from POA reporting as determined by CMS, that code will be included in the DRG grouper.

The Centers for Medicare and Medicaid (CMS) has a defined listing of ICD-9-CM diagnosis and procedure codes that are Hospital Acquired Conditions. DMAS has adapted these same diagnosis and procedure codes. For a complete listing of the codes, please refer to the Centers for Medicare and Medicaid Services (CMS) website at: http://www.cms.hhs.gov/HospitalAcqCond/Downloads/HACFactsheet.pdf.

Managed Care Organizations (MCOs)

Many Medicaid recipients are enrolled with one of the Department's contracted MCOs. In order to be reimbursed for services provided to an MCO enrolled individual, providers must follow their respective contract with the MCO. The MCO may utilize different prior authorization, billing, and reimbursement guidelines than those described for Medicaid fee-for-service individuals. For more information, please contact the MCO directly.

REQUESTS FOR DUPLICATE REMITTANCE ADVICES

In an effort to reduce operating expenditures, requests for duplicate provider remittance advices will no longer be printed and mailed free of charge. Duplicate remittance advices will be processed and sent via secure email. A processing fee for generating duplicate paper remittance advices will be applied to paper requests, effective July 1, 2009.

ALTERNATE METHODS TO LOOK UP INFORMATION

Effective August 1, 2009, DMAS authorized users now have the additional capability to look up service limits by entering a procedure code with or without a modifier. Any procedure code entered must be part of a current service limit edit to obtain any results. The service limit information returned will pertain to all procedure codes used in that edit and will not be limited to the one procedure code that is entered. This

is designed to enhance the current ability to request service limits by Service Type, e.g., substance abuse, home health, etc. Please refer to the appropriate Provider Manual for the specific service limit policies.

ELIGIBILITY VENDORS

DMAS has contracts with the following eligibility verification vendors offering internet real-time, batch and/or integrated platforms. Eligibility details such as eligibility status, third party liability, and service limits for many service types and procedures are available. Contact information for each of the vendors is listed below.

Passport Health Communications, Inc. www.passporthealth.com sales@passporthealth.com Telephone: 1 (888) 661-5657	SIEMENS Medical Solutions – Health Services Foundation Enterprise Systems/HDX www.hdx.com Telephone: 1 (610) 219-2322	Emdeon www.emdeon.com Telephone: 1 (877) 363-3666

ELIGIBILITY AND CLAIMS STATUS INFORMATION

DMAS offers a web-based Internet option (ARS) to access information regarding Medicaid or FAMIS eligibility, claims status, check status, service limits, prior authorization, and pharmacy prescriber identification. The website address to use to enroll for access to this system is http://virginia.fhsc.com.

The MediCall voice response system will provide the same information and can be accessed by calling 1-800- 884-9730 or 1-800-772-9996. Both options are available at no cost to the provider.